2016 Health and Life Insurance RETIREE – Election Form

OPEN ENROLLMENT

Do <u>not</u> complete this form unless you are making changes.

PRIMARY INFORMATION – please <u>PRINT</u>

You may use this form to make changes for 2016. Or, if you have an AccessMCG account, you can make changes online (see the Open Enrollment Guide). Based on your changes, **<u>additional paperwork may be required</u>** as outlined in the Open Enrollment Guide. The deadline to make changes and for OHR to receive **<u>all</u>** required paperwork is **<u>November 6, 2015</u>** at 5:00 p.m. ET.

Retiree ID: _____
(Shown at the top of your Fact Sheet)

Name: _____

Street Address: _____

City, State, ZIP Code: _____ _____ _____

Telephone Home #: (_____) _____ – _____ Cell #: (_____) _____ – _____

Email Address: _____
*Your email address will not be shared and will **only be used by OHR** to contact you regarding your health insurance.*

Medical (choose one)

- ❑ No Medical
- ❑ Kaiser HMO (includes Kaiser Rx)
- ❑ United HealthCare HMO
- ❑ CareFirst POS High Option
- ❑ CareFirst POS Standard Option

For eligible participants living outside the POS service area:

- ❑ CareFirst POS High Option Out-of-Area
- ❑ CareFirst POS Standard Option Out-of-Area

Dental (choose one)

- ❑ No Dental Coverage (2-year waiting period to re-enroll)
- ❑ Dental PPO (traditional dental plan)

Vision Plan (choose one)

- ❑ No Vision Coverage
- ❑ Discount Vision

Prescription / Rx (choose one)

For Kaiser and Indemnity plan participants, no Rx election is needed as Rx coverage is included in your plan

- ❑ No Prescription Coverage
- ❑ High Option $5/$10
- ❑ Standard Option $10/$20/$35

Optional Life (choose one)

- ❑ Cancel Optional Life Coverage
- ❑ Keep Current Optional Life Coverage

Dependent Life (choose one)

- ❑ Cancel Dependent Life Coverage
- ❑ Keep Current Dependent Life Coverage

Over ↺

DEPENDENT COVERAGE – please PRINT

To add or delete dependent coverage, complete the section below and **include copies of the required documentation** (e.g., birth certificate, adoption certificate, marriage certificate, etc.) as outlined in the Open Enrollment Guide. Note that you must have elected the same coverage for yourself in the medical, prescription, dental and/or vision sections of this form as you do below for your dependents (e.g., your dependent may not have the vision plan unless you do). Also, the number of dependents you cover under each plan will determine your coverage level (Self, Self+1 or Family) and your cost for each plan.

❑ **Add Eligible Dependent(s)** ❑ **Keep Same Dependent Coverage**

SOCIAL SECURITY *(Required)*	FULL NAME OF ELIGIBLE DEPENDENT	DATE OF BIRTH	GENDER	RELATIONSHIP *(see the Open Enrollment Guide)*	INSURANCE ELECTIONS
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision
					❑ Medical ❑ Dental ❑ Rx ❑ Vision

❑ **Delete / Disenroll Dependent(s)**

FULL NAME OF DEPENDENT	NO LONGER ELIGIBLE	COVERAGE TO BE CANCELLED
	❑	❑ Medical ❑ Dental ❑ Rx ❑ Vision
	❑	❑ Medical ❑ Dental ❑ Rx ❑ Vision

SIGNATURE (must be signed to be effective)

I have read the materials available for the County's Group Insurance Plan. I authorize the County to make a deduction from my ERS or LTD2 benefit for my insurance elections. If I pay directly for insurance, I will promptly pay the cost or benefits will terminate. I understand that I can only change my elections if I have a Status Change (see Summary Description). I also understand that the County may adjust my elections. I authorize the release of enrollment information to the extent necessary to properly administer my elections. I understand that electing benefits to which I or any other person is not entitled is considered fraud and if I misrepresent my eligibility or that of any other person, or fail to take the steps necessary to remove ineligible persons, or in any way obtain benefits to which I am not entitled, benefits will terminate. In addition, I must repay any claims which have been paid inappropriately, and I may face charges. I understand that the County expects to continue the Plan, but it is the County's position that there is no implied contract between members and the County to do so. I also understand that the County reserves the right at any time and for any reason to amend the Plan, subject to any applicable County's collective bargaining agreements. The County may also amend the Plan, prospectively or retroactively to comply with applicable law.

➪ **Signature:** _____ **Date:** _____

IMPORTANT: **All documents MUST be signed and received by 5:00 p.m. ET, Friday, November 6, 2015.**

Mail to: OHR Health Insurance Team, 101 Monroe St., 7th Floor, Rockville, MD 20850
or fax: 240-777-5131 (include fax/mail cover sheet)

Reminder: When you receive your Medicare card, be sure to send us a copy via fax or to the address above.

Rev. 09/18/2015